



# 2019 Health Care Industry Outlook

Prepared by Foley's Health Care Practice

## Foreword

A new wave of change is poised to disrupt the way health care is delivered in the United States. This time around, the disruption is coming not from lawmakers or the president, who have struggled to repeal or improve upon Obamacare. Rather, it is coming from a wide variety of both new entrants and established players. Some hope to make meaningful improvements, while others are seeking an entirely new approach.

Rising costs are a key driver and persistent health care inflation is by no means a new story. But it has arguably gotten out of control – health spending accounted for [17.9 percent](#) of GDP in 2017. That’s more than \$10,300 per person and rivals the [tax receipts](#) of the federal government. Warren Buffet has [called](#) health care costs “the major problem of our economy.”

Some of the nation’s most powerful and innovative companies are stepping up to tackle what the government has been unable to do, shifting the balance of health care problem solvers. [Google](#), [Apple](#) and others have announced initiatives. Perhaps the highest-profile upstart is a joint project by JPMorgan Chase, Berkshire Hathaway and Amazon, [led](#) by prominent surgeon and best-selling author Atul Gawande.

Many of these would-be problem solvers want to cut costs by eliminating intermediaries and providing services directly to patients. Amazon recently purchased online pharmacy PillPack and now has pharmacy licenses in 49 states. Another venture, [a nonprofit initiative](#) to address the high costs and shortages of generic medications, was launched by four major health systems (Intermountain, SSM, Ascension and Trinity) and the Department of Veterans Affairs. At least [70 hospital systems](#), representing a third of the hospital market, have expressed an interest in joining.

As tech companies enter the health care ring, new technologies are bringing advances to the way health care is managed and delivered. In particular, artificial intelligence (AI) is touching virtually every aspect of the business, improving efficiency, patient care, supply-chain management and profitability (see our [2017 Telemedicine & Digital Health Survey](#) for information about providers and patients embracing technology).

On the regulatory front, with Congress repeatedly failing to improve on Obamacare, state governments have started to confront the challenge. They are fighting costly care by passing initiatives to bring greater transparency and price management – and some states are even imposing price controls. Health care was the [standout issue](#) in midterm campaigning. After the elections, drug stocks rallied on the idea that congressional gridlock would lower the likelihood of price-control legislation. With the Democrats in the House, [Obamacare is likely safe](#), and the “Medicare for all” [debate will persist](#). State election results support the continued expansion of Medicaid, with three conservative states adopting initiatives to expand access.

The Centers for Medicare and Medicaid Services (CMS) is also actively innovating. CMS is experimenting with direct to primary care provider contracting. It is also revamping initiatives, such as the Medicare Shared Savings Program’s Accountable Care Organization program, to make providers more accountable and to take on additional risk. There is also speculation CMS has mandatory bundled payments in the pipeline.



A long-awaited demographic trend is adding urgency to the cost crisis. As baby boomers reach old age, the country faces new challenges, some of which will present opportunities for health care organizations, particularly in the area of Medicare Advantage. Obamacare, an attempt to expand coverage to population sectors that may have had difficulty securing coverage under existing systems, is currently being challenged in the courts, and has continued to attract criticism and unsuccessful attempts at improvements or rescission. Meanwhile, as the opioid crisis ravages younger populations, the health care system is looking to prevention to help patients recover and to reduce the burden posed by this epidemic.

In this report, we have assembled secondary-source research detailing these developments and the effect they are expected to have on the industry.

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## Market Intelligence

The health care industry experienced a wave of disruption when Obamacare was ushered in. Obamacare increased the focus on accountability and, with the creation of the exchanges, enhanced some elements of consumerism as well as expanded Medicaid. The current administration has, so far, unsuccessfully pushed to dismantle Obamacare (using both Congress and the courts), and despite a federal judge in Texas [ruling](#) the Obamacare health care law unconstitutional, industry forces initially enhanced by Obamacare show no sign of slowing.

According to recent health care industry outlooks and surveys, including reports by [PwC](#) and [Avalere Health](#), the leading trends and issues facing the industry include:

- The ongoing struggle to improve price transparency and enhance the patient care and member experience
- Navigating the burgeoning Medicare Advantage market and adapting to the aging population
- Establishing the employer as a direct provider of health care
- Shifting to alternative payment models and value-based care
- Combatting the opioid crisis
- Safely implementing emerging technologies like AI and the Internet of Things (IoT) to unlock efficiencies and improve care

The outcomes of these converging trends for the industry are:

- Continued focus on collaboration between health care organizations and non-health care organizations via investments, partnerships and acquisitions
- Emergence of new solution providers from technology, finance and other fields developed outside of health care
- Greater reliance on technologies and new forms of contracts and care practices to drive patient experience, reduce system waste and promote accountability in care

### Price Transparency and Value-Based Care

Our high-cost health system is increasingly unacceptable to consumers. Consumers, regulators, policymakers and the industry itself continue to push back on factors that are driving costs. The federal government and several states have [launched](#) pricing and transparency initiatives, and though this trend will continue, transparency remains complicated and controversial. Legislative and corporate initiatives focus on gaining better control of provider and pharmaceutical prices and exposing significant cost increases. Although early focus was on the pharmaceutical industry, now payers and providers are having to divulge their pricing information as well. Several states are instituting price controls, requiring increased transparency and greater detail on hospital costs.

States are increasingly focusing on consumer protection and billing policies, especially the issue of balance billing. Advocates [are seeking](#) to establish standards for transparent and fair benefits for out-of-network services and for adequate network coverage.

Payers and startups are also [using digital technology](#) to bring greater transparency to health care pricing. Insurers like [Priority Health](#) and [UnitedHealthcare](#) offer online price estimators that promise to cut patient bills, although the insurers say awareness is low and only a small number of patients use these tools. Meanwhile, investors are pouring millions into a new breed of health care transparency tools. For instance, [Amino](#), which offers real-time price estimates powered by \$3 billion in annual health insurance claims data, has raised \$45 million. [Mpirica Health](#), which rates hospitals, raised \$4.6 million, led by a crowdfunding platform and supported by a private equity fund. And [Zocdoc](#), which helps book in-network appointments, has raised \$223 million.



### TWEET THIS

Foley's latest Health Care Outlook report digs into how the #healthcare industry is using digital #technology to bring greater pricing transparency to consumers.



Meanwhile, [value-based payment models](#) will continue to be a tool for improving outcomes and controlling costs. The value-based care wave [has given rise](#) to [many joint ventures](#) between providers, employers and commercial insurers. Although the shift to value-based care is in motion, the industry still [needs the proper tools](#) to be able to administer alternative payment models. According to a 2018 [study](#), 57 percent of health care executives said they do not believe physicians have the tools to succeed under value-based care, up significantly from 45 percent the previous year.

There is a call for increased co-investment between payers and providers in health care IT – including AI, machine learning, predictive analytics and blockchain – to improve alignment and accelerate value-based care adoption. For instance, most health plan [executives say](#) that blockchain can help surmount interoperability by sharing data among organizations; this is critical as providers take on more risk, given that plans have data that providers lack. Likewise, AI can be harnessed to help providers, who are now bearing more risk, achieve better outcomes. Likewise, analytics [can be used](#) to scrutinize financial, operational and clinical outcomes; to optimize what's working; and to embed it in an organization's value-based strategy.

### Medicare Advantage and the Aging Population

According to an article by Federally Qualified Health Center (FQHC) Germane, a health care consulting firm, “the United States is [experiencing](#) a wave of aging population,” referred to as the Silver Tsunami, as the number of seniors over the age of 65 has surpassed 50 million for the first time. Within the next 25 years, this number is expected to surpass 70 million. This long-expected change in consumer

demographics is creating both opportunities and challenges for the health care industry. On the health care coverage side, the market for Medicare Advantage (the private alternative to Medicare) [continues](#) to swell. [Nearly 33%](#) of Medicare's overall beneficiaries (or 19 million people) were enrolled in Medicare Advantage plans in 2017, and that number is expected to grow.

With the growing senior consumer population, competition in the Medicare Advantage market is heating up and some players are being squeezed out of the market. Seniors are flocking toward plans that can demonstrate high quality and performance rankings and are expecting more from their plans than seniors have in the past. Aging baby boomers can be smart, tech-savvy consumers who are accustomed to online retail experiences. Additionally, tech-driven plans are entering the market, taking more direct control of patient care and bringing new technologies and approaches to care to the table. Insurers now must identify digital health and consumer experience strategies that ward off these new entrants and cater to seniors, something they didn't have to worry about in the past.

On the provider side, the industry is adjusting to an influx of seniors that are set to enter the care system. While demand is increasing, there are also [pressures on](#) the supply side. It's expected that about [21,500 certified geriatricians](#) will be needed to care for the aging population (four times the amount of the [current supply](#)). Between 2010 and 2015 there was a [21% decrease](#) in the number of first-year geriatrics residents. With the Trump administration taking a tougher stance on immigrants who currently fill geriatric care jobs, it's [expected](#) that many senior caregivers and home aids could be impacted. While staffing is an issue, so too is the stress that the Silver Tsunami will create on care infrastructure and cost. In order to cope with increased need, the industry is exploring new care models and technologies that can help seniors age at home.





### Modifications to Stark Law

Stark Law, banning physician self-referrals, is said to be hindering the value-based, patient-centered health care system and alternative payment model. “The American Hospital Association (AHA) has been vocal in pushing for changes to the physician self-referral law, calling it outdated,” according to a June 21, 2018, article by [Healthcare Dive](#). “To reach the full potential of a value-based health system, the Stark compensation regulations must be reframed to meet the objectives of the new system, through the creation of a new exception designed specifically for value-based payment methodologies,” *the AHA wrote*, responding to a CMS request for information on reducing the law’s regulatory burdens.

Additionally, the AHA stresses that personal services exceptions should be modified to include the Medicare fee-for-service population so that value-based care can be enjoyed by all patients, and that risk-sharing exceptions, currently applicable to providers at financial risk, should be extended to “arrangements involving Medicare, Medicare Advantage and Medicaid,” according to an August 7, 2018, article in [RevCycleIntelligence](#). Since CMS issued a request for information (RFI) in June 2018 to discover how care coordination and alternative payment model participation are being hindered through the Stark Law (first introduced in the late 1980s and substantially amended over the past three decades), industry stakeholders have been open in voicing their opinions and pushing for changes and revisions needed to foster improvement in health care. In late August, as CMS’s RFI period was closing, the HHS Office of Inspector General [published](#) its own RFI on “how to address any regulatory provisions that may act as barriers to coordinated care or value-based care.”

### Senior Living Industry Trends

Increased vertical integration between senior living providers, health systems and payers is on the rise, as evident from joint ventures between ProMedica, a nonprofit health care system and HCR ManorCare, a large post-acute and long-term care provider, as well as between Post-Acute Medical, LLC, a rehabilitation and long-term acute care provider, and Be Healthy at Home, a home health care organization. In a July 2018 conference call captured by [Senior Housing News](#), Welltower CEO Tom DeRosa commented that “this transaction is a glimpse of the future” and that “this new joint venture will be a template for how senior housing and care can be more integrated into health systems, to more effectively manage costs and maximize quality of life for the country’s growing population of older adults.”

Since the payment model has shifted from capitated rate to value-based reimbursement, health care systems showing interest in the idea of integration is no surprise. Moreover, according to [CliftonLarsonAllen’s 2018 report](#) on senior living trends, “The significant growth in the ‘longevity economy’ (composed of 106 million people responsible for at least \$7.1 trillion in annual economic activity – a figure that is expected to reach more than \$13.5 trillion in real terms by 2032 according to AARP),” presents huge investment opportunities in the senior living industry. Currently, health systems are realizing the power these relationships can provide them – the power to control “more of the care continuum, to create a ‘circle of wellness’ for patients that keeps them out of the hospital and other high-cost settings,” according to a [Senior Housing News article](#).

While providers, payers and policymakers want to focus on post-acute care integration into the health system, lack of sophisticated [revenue cycle management systems](#) to unify billing across several post-acute care facilities is still a big roadblock, according to Joe Morris, chief information officer at Landmark Hospitals. “A lot of the products that are out there started for short-term acute care facilities and were not designed for long-term acute care facilities,” he told [RevCycle Intelligence](#) in July.

### Growth of Telehealth and Telepharmacy

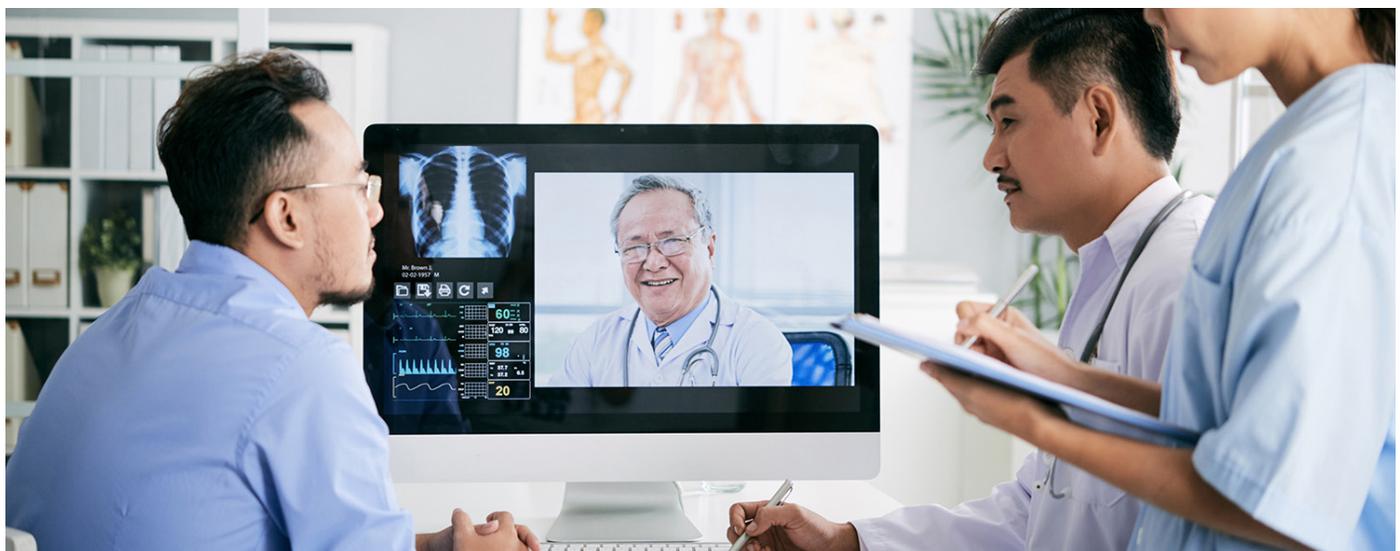
Non-direct provider interactions, such as telehealth and telepharmacy, are becoming far more prevalent. This is being driven by a variety of factors, including a desire to reduce costs, the development of new technologies and patients’ and payors’ receptiveness to these new approaches. CMS has made it possible for physicians to bill for remote physiological monitoring in chronic care, issuing several new fee schedule codes in 2018. This will likely [prompt](#) health care providers to launch such programs. CMS has also proposed new codes that would expand the use of telemedicine, allowing providers to bill for peer-to-peer internet consultations, virtual check-ins and “asynchronous telemedicine.” Payment for the latter, which involves analyzing patients’ images and videos, [sends a strong message](#) that asynchronous telemedicine is an important and clinically valid tool.



#### TWEET THIS

What’s driving the growth of #telemedicine and #telepharmacy across the health care industry? That and more in Foley’s latest #healthcare report.

Telepharmacy, while not necessarily a new concept, is beginning to gain more attention in the health care industry as a tool to improve patient care and coordination of pharmacy patient care and medication adherence. According to [Telemedicine magazine](#), “Telepharmacy is growing, but the available technology is still underutilized. While the proof points for patient safety are well developed, the industry is now becoming more nuanced, exploring potential benefits of telepharmacy from an operational standpoint.” With increased telepharmacy use comes the issue of pharmacy providers following the right licensure requirements, which is complicated as the pharmacies can provide interstate service to patients, requiring the pharmacy and at least one pharmacist to have the license or some form of permit in the state where the patient resides. An article authored by Foley attorneys for [Compliance Today](#) points to the National Association of Boards of Pharmacy’s Model Act and Rules as enlightening on this challenge of multistate pharmacy practice: “The practice of telepharmacy is deemed to occur within the jurisdiction in which the patient is located and the jurisdiction(s) in which the pharmacist and, if applicable, pharmacy are located; therefore, such practice will be subject to the pharmacy practice regulations of all jurisdictions’ boards of pharmacy.” The rules or regulations authorizing the use of telepharmacy are not uniform across states, further aggravating attempts to offer telepharmacy.



## Drug Pricing Battle

The issue of increasing list prices of drugs prevails, though the prices are increasing at a slower pace as compared to a few years ago. Rebates have also been increasing. According to an August 7, 2018, article in [Forbes](#), “Companies say that the rebate growth rate has outstripped list prices. Pharmacy benefit managers (PBMs) assert that through rebates they’re stemming increases in premiums.... The insured are faced with ever-rising premiums and cost-sharing. And, without negotiating clout the growing ranks of uninsured pay the full retail price of prescription drugs.”

The Trump administration is expected to attempt significant structural changes in the pharmaceutical industry. In the May 2018 unveiling of the Department of Health and Human Services (HHS)’s blueprint titled “American Patients First,” the FDA commissioner said that he was against branded manufacturers blocking generic products from entering the market. Moreover, HHS presented some policies that will help improve price transparency for consumers and establish indication-based pricing. And HHS proposed a rule in July 2018 titled “Removal of Safe Harbor Protection for Rebates to Plans or PBMs Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection” and submitted it to the Office of Management and Budget (OMB) for regulatory review. This rule would “scale back protections currently in place that allow rebates between drug manufacturers and insurers and pharmacy benefits managers,” according to a July 19, 2018, article in [Reuters](#). The proposed rule is not yet public, and while the OMB reviews it, the industry will closely monitor all developments as this would bring about a huge change to PBMs’ market.



### TWEET THIS

Are you up to speed on the Trump administration’s plans for tackling #drugpricing in 2019? More on how companies should prepare in @FoleyandLardner’s Health Care Outlook white paper.

## A Reimagined Middleman

The health care industry’s middlemen – intermediaries such as PBMs and wholesalers – continue to make significant investments in increasing the availability, efficiency and safety of dispensing. Nonetheless, PBMs have faced legislative and public opinion [challenges](#). As part of a broad effort to contain health care inflation, some lawmakers and regulators are eager to see greater transparency in PBM pricing and rebate practices. Meanwhile, the competitive landscape is shifting as insurers [acquire and merge with PBMs](#). Wholesalers are facing financial struggles due to the ongoing deflation in generic drug pricing and because manufacturers are limiting branded-drug price increases due to public pressure. The market value for the health care industry’s middlemen [declined](#) nearly 30% between 2015 and 2017.

New industry entrants, like Amazon, are creating added pressure for traditional middlemen to demonstrate their value. In response to this disruption, PBMs are forming closer ties with insurers through acquisition or reimagining their business models by turning to value- and/or evidence-based care models.

## Opioid Crisis and Social Determinants

Policymakers, health care organizations and consumer advocates continue to attempt to combat the opioid crisis, which is the leading cause of death in the United States for adults younger than 50. According to American Action Forum [estimates](#), it cost the U.S. economy \$702 billion in GDP between 1999 and 2015 due to people leaving the workforce. Between 2016 and 2017, emergency department visits for suspected opioid-related overdoses increased 30%, [according](#) to the Center for Disease Control. In October 2017, the White House officially [declared](#) the epidemic a national emergency but did not successfully provide a pathway to meaningful funding for the effort.



Health care organizations will continue to [focus](#) on building capabilities and collaborative opportunities that allow them “to prevent opioid misuse, improve treatments for chronic pain and support patients struggling to recover from opioid addiction,” according to PwC Health Research Institute’s 2018 [annual report](#). Critical to these efforts are identifying and funding behavioral markers and social health determinants (e.g., food security, loneliness and social inclusion), monitoring pharmacy/claims data, reducing unnecessary opioid prescriptions by placing restrictions on prescribing practices and changing drug formularies, and working alongside first responders to expand access to medication-assisted therapy and drugs such as naloxone.

These efforts will require investing in increased patient/member engagement and relying more heavily on technology and data, as well as ensuring care programs and coverage promote alternative – and less expensive – pain management treatments.

### Internet of Things and Artificial Intelligence

Drawing on its momentum and disruption in other industries, AI is gaining traction in health care and altering the entire market – from patient care to back-end management and supply chains. AI is being [leveraged](#) by health care companies to enhance back-end decision-making, financial reporting and supply chain management, and to streamline regulatory compliance functions. Providers are also turning to AI to support patient care, leveraging it to more rapidly and accurately analyze test results, allowing them to see more patients and generate more revenue. Leading areas of provider investment include [virtual personal assistants](#), automated data analysts, automated communications (chatbots) and automated information aggregation. Medicare is encouraging the trend by proposing changes to reimbursement policies to allow payment for new devices.

On the consumer side, 65% of consumers [say](#) they’ve experienced health-related AI and are attracted to the convenience of AI-backed health services. Consumers are [becoming](#) increasingly sophisticated in their use of health care technology and opening up to intelligent health technologies, but providers are not currently living up to consumer interest in the virtual care arena. Importantly, the entry of Amazon into the health care industry has [implications](#) for AI as Amazon has made significant strides with the technology through its Alexa assistant, which has been leveraged by Mayo Clinic to provide first-aid information and voice-driven self-care instructions.

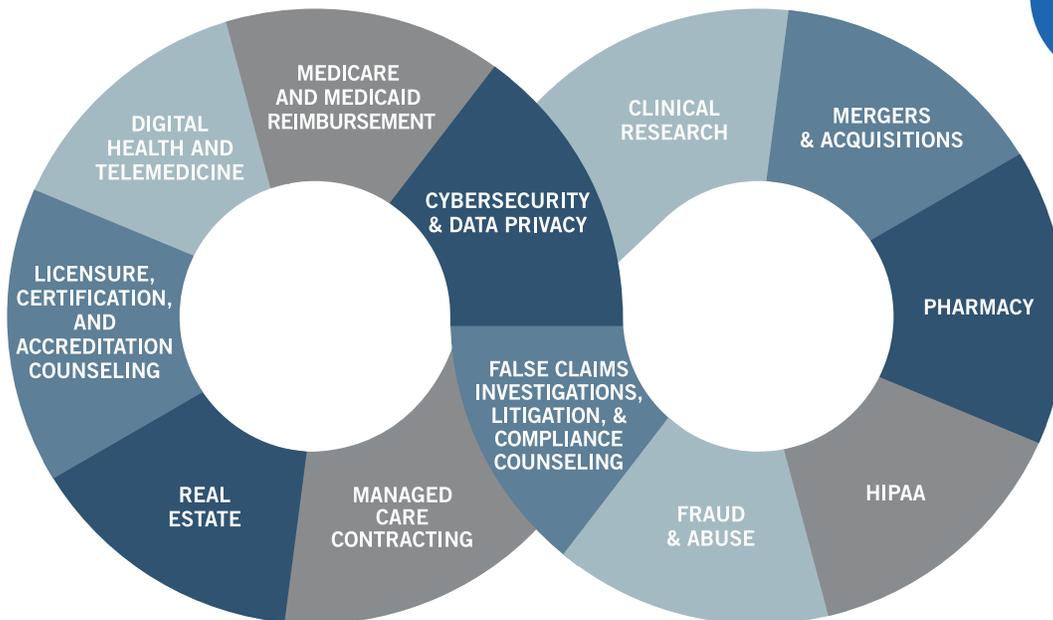
In parallel, the industry is experiencing a proliferation of internet-connected medical (and non-medical) devices, which are playing increasingly prominent roles in patient care, record keeping and billing. In two years, the use of IoT solutions like smart scales, wearables and social platforms has [nearly doubled](#). However, IoT devices may come under threat from cybercrime – health care is an alluring target because it is one of the most data-rich industries. The industry has seen significant data breaches, with a “525% increase in medical device cybersecurity vulnerabilities reported by the government,” according to PwC Health Research Institute’s 2018 [annual report](#). Providers need to be proactive in data privacy, particularly as hospitals become common targets for ransomware attacks such as WannaCry, which affected several medical device makers.

Visit Foley’s [Health Care Law Today](#) blog for the latest insights into health care law.

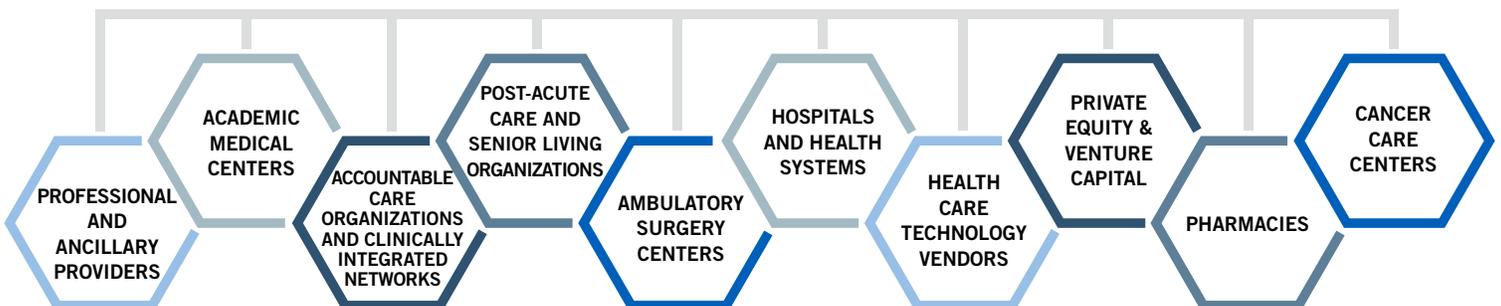
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On April 1, 2018, Foley combined with Gardere Wynne Sewell LLP. The combined firm operates as Foley Gardere in Austin, Dallas, and Houston. In Mexico City, the firm operates as Foley Gardere Arena. All other offices operate as Foley & Lardner LLP.

# Our Core Values

## **Clients First**

Our clients are our first priority. When we provide quality work, value and superior service to our clients, our own success inevitably follows.

## **Diversity**

We embrace diversity and are committed to the inclusion of our diverse attorneys and staff and to the success of all our people.

## **Integrity**

We will adhere to high standards of ethics, professionalism and integrity and safeguard the reputation of the firm at all times.

## **Trust and Respect**

The success of our partnership stands on a foundation of trust, mutual respect, collegiality, communication and teamwork.

## **Stewardship and Accountability**

As stewards of the firm, we are accountable to one another and will commit our time, talent and energy to the firm's success, growth and long-term prosperity.

## **Citizenship**

We embrace our responsibilities to our communities and profession and will lead by example through civic, pro bono, professional and charitable service.

## **Professional Satisfaction**

Our work should be professionally satisfying and provide competitive financial rewards while affording the opportunity to achieve a reasonable balance between professional demands and personal commitments.

## **Our People**

Our people are our most valuable asset and their quality, creativity and dedication are indispensable to our success.



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